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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	Enforcement Matter No.: 06-214
Blue Cross of California	OAH No.:
	ACCUSATION
Respondent.	(Health & Safety Code section 1389.3)

I.

INTRODUCTION

1. This case is brought pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended, Health & Safety Code section 1340 et seq. (the "Act"). The Accusation is based on a course of conduct by Respondent regarding an enrollee whose health care coverage was wrongfully rescinded. Specifically, Blue Cross of California ("Respondent") failed to complete pre-enrollment medical underwriting and failed to resolve all reasonable questions arising from written information submitted on or with the application before issuing health care coverage to the Enrollee and her family. Respondent also failed to prove that the enrollee willfully misrepresented her health history before rescinding coverage, as the law requires. As a result, the Enrollee's security of having health care coverage was taken from her without legal justification. In addition, the Enrollee was forced to pay for all health care services provided to her during the time she had a contract for health care coverage from Respondent and forced to pay out of pocket for her future health care costs which should have been covered by Respondent.

2. By this conduct, Respondent wrongfully rescinded the Enrollee's health care coverage in violation of the Act and Respondent's own policies and procedures for pre-enrollment underwriting and post-claims review for possible rescission of coverage as more fully set forth below.

3. The Respondent's conduct is contrary to the provisions of the Act referenced below and constitutes cause for discipline by the Director of the Department of Managed Health Care pursuant to Health and Safety Code section 1386 generally, and specifically subdivisions (a) and (b)(6).

II.

PARTIES

4. Amy L. Dobberteen (the "Complainant") is the Assistant Deputy Director of the Office of Enforcement in the Department of Managed Health Care. She brings this Accusation solely in that official capacity.

5. At all times pertinent to the allegations herein, Respondent has been a full-service health care service plan as defined by Health and Safety Code section 1345, subdivision (f), and is subject to the regulatory provisions of the Act.[1] Respondent is the holder of health care service plan license number 933-0303, issued on January 7, 1993 by the Commissioner of the Department of Corporations, predecessor to the Director of the Department of Managed Health Care of the State of California.[2] Respondent's principal corporate office is located at 21555 Oxnard Street, Woodland Hills, California 91367.

III.

JURISDICTION & STATURORY AUTHORITY

6. This Accusation is brought by the Director of the Department of Managed Health Care under the specific grants of authority in the following sections of the Health and Safety

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[1] All references are to the Health & Safety Code unless otherwise noted.

[2] At the time Respondent applied for, and was granted, a license to become a health care service plan, the Department of Corporations was the regulating entity issuing licenses and enforcing the Knox-Keene Act. Effective July 1, 2000, the Department of Managed Health Care succeeded to all duties, powers, responsibilities, and jurisdiction of the Department of Corporations as they related to Corporations' Health Plan Program, Health Care Service Plans, and the Health Care Service Plan Business. (Health & Saf. Code § 1341.9).

Code.

7. The Act was passed in 1975 to provide for state regulation of health care service plans. In 1999, the Act was amended to create the Department of Managed Health Care within the California Business, Transportation, and Housing Agency. The Department is charged with the execution of California laws relating to health care service plans. Its statutory mission, as set forth in section 1341, subdivision (a), is to ensure that health care service plans provide enrollees with access to quality health care services and to protect and promote the interests of enrollees.

8. The Director of the Department is vested with responsibility for the administration and enforcement of the Act and the rules and regulations promulgated pursuant to section 1341. Section 1386, subdivision (a) authorizes the Director to take disciplinary action against a health care service plan, including, but not limited to, the assessment of administrative penalties against the plan, if the Director determines, after appropriate notice and opportunity to be heard, that the plan has committed any of the acts or omissions that are grounds for disciplinary action.

9. Section 1389.3 of the Act prohibits post-claims underwriting and provides:

> No health care service plan shall engage in the practice of post-claims underwriting. For purposes of this section, "post-claims underwriting" means the rescinding, cancelling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application before issuing the plan contract. This section shall not limit a plan's remedies upon a showing of willful misrepresentation.

10. Among the acts or omissions of Respondent that warrant disciplinary action are the following:

(a) Failing to complete medical underwriting before issuing the plan contract;

(b) Failing to resolve all reasonable questions arising from the information submitted on or with the application for health care coverage before issuing the plan contract;

(c) Failing to make a showing that the Enrollee willfully misrepresented her health history before rescinding her health care coverage.

11. By reason of the conduct described below, Respondent is subject to disciplinary action under section 1386 and to the assessment of an administrative penalty for multiple violations of Health & Safety Code section 1389.3.

IV.

FACTUAL ALLEGATIONS

12. The Enrollee applied for a Blue Cross PPO Share 2500 Plan for her and her family on May 21, 2004 after relocating to the United States from Canada. The Enrollee disclosed an extensive amount of health history for herself, her husband and her children on the health history portion of Respondent's application. She answered "Yes" to the following body systems: Brain/Nervous; Heart/Circulatory; Digestive; Musculoskeletal and Nervous, Mental, Emotional, Behavioral. The Enrollee also explained each "Yes" answer on section 6C of the application and disclosed her husband's chronic pain condition and her daughter's depression. Based on the Enrollees' family health history, Respondent declined to cover the Enrollee's husband because of his chronic pain condition, but approved coverage for the Enrollee and her three children.

13. Respondent delayed approval of the Enrollee's (and her family's) coverage until she provided proof of U.S. residency because of her family's recent move from Canada. The Enrollee provided proof of residency to Respondent on June 10, 2004. Included in the Enrollee's documentation of proof of residency was a letter from the Enrollee disclosing two tests that were not disclosed on her initial application. Specifically, the Enrollee stated:

> I believe there were two tests that I have forgotten to include in the details for myself. Approx. eight years ago I had an ultrasound (UTZ) to follow up on the reflux surgery: No changes. Also, approximately five years ago I had a test for gastric reflux symptoms: No cause noted. Both tests were ordered by Dr. Woo, Rexdale, Ontario (Canada).

Because the proof of residency was required before the Enrollee's coverage was approved, Respondent had additional health information to evaluate before issuing the plan contract based on the tests disclosed in Enrollee's June 10, 2004 letter, but failed to do so.

14. The June 10, 2004 letter disclosed that the Enrollee had "reflux surgery" but she did not provide the date of the surgery or for what condition the "reflux surgery" was required.

Respondent made no attempt to follow up on the date of the surgery or why the Enrollee required the "reflux surgery." Had Respondent contacted the Enrollee to follow up on these questions, she could have explained that her "reflux surgery" was successfully performed more than 23 years before she applied for coverage with Respondent to cure her pyelonephritis condition. However, it was this cured prior condition that Respondent relied on to rescind the Enrollee's health care coverage. Additionally, the Enrollee could have explained (or requested her physician to provide an Attending Physician Statement) regarding her pyelonephritis diagnosis, and successful treatment, which would have allowed Respondent to resolve all reasonable questions submitted on or with the application before approving coverage for the Enrollee and her family.[2] Respondent failed to do so.

15. The Enrollee had a history of pyelonephritis (kidney infection) caused by reflux of urine into her kidneys, 29 years before she applied for coverage with Respondent. Her ureters were reimplanted twice, at fourteen and eighteen years of age. This resolved the pyelonephritis but she was left with a shrunken right kidney. As a result, the Enrollee's pyelonephritis was corrected by surgery more than twenty years before she applied for coverage with Respondent and other than having routine tests to confirm the Enrollee's kidneys were functioning properly, the Enrollee's medical records do not reflect any further complications from pyelonephritis.

16. A visit to Aragon Medical Center for an annual exam and consultation with a Physician Assistant on August 26, 2004 generated a medical claim received by Respondent in October 2004. The claim contained the following diagnoses:

- 1) ICD 782.2 on 8/26/04, (soft tissue mass rt. [right] temple)
- 2) ICD.9 code 593.9 (diseases of the kidney). (BCC 116850 - 116851)

ICD-9 code 593.9 prompted Respondent to request a copy of the Enrollee's medical record from the Aragon Medical Center on October 5, 2004. A letter of inquiry and notification was sent to

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[2] Although the effective date of the Enrollee's coverage was June 1, 2004, Respondent's final approval of the Enrollees' application came after it received the June 10, 2004 letter confirming residency and disclosing the additional tests. The affirmative answers on the application regarding health history, together with the information submitted with the application for final approval should have caused Respondent to realize that it had not resolved all reasonable questions before issuing plan coverage.

the Enrollee on October 10, 2004. In the letter, the Enrollee was asked to provide additional information on the following conditions: rheumatoid, kidney disease, and migraines.

17. On October 29, 2004 Respondent sent its MR26 letter to Enrollee requesting additional medical records from her providers in Canada. The letter listed the following health history disclosed by Enrollee to Regina Peterson, the Physician Assistant who saw her for her annual exam at the Aragon Medical Center:

> Medical records submitted from Humberto Aragon, MD documented the following:
>
> - August 26, 2004 – annual exam; history of menses are changing – migraines at end instead of beginnings. 15 years ago – rheumatoid. L-75%/R-25% kidney tx (treatment reimplant ureters, large L-kidney.
> - Cervix and uterus exam: "retroverted, could not obtain good Pap results."
> - Derm exam: "small, movable non-tender mass R temple – suspect lymph nodes vs. cyst, kidney disease 593.9, well woman v70.0. (BCC 116845)

18. The Enrollee responded to the Plan in writing on November 11, 2004 and provided clarification on what she thought were errors made by the Physician Assistant who obtained her health history during her annual exam on August 26, 2004. The Enrollee wrote:

> - I have never been seen for rheumatoid arthritis. I had symptoms of reactive arthritis fifteen years ago following an episode of food poisoning.
> - I did not have kidney disease. My kidney damage was caused by reflux as indicated on my medical record and corrected by surgery (20 some years ago) as indicated on my records.
> - I have never had a history of migraines. What I had said to the doctor was that I used to have mild headaches before my period was due (an indicator as opposed to having cramps) but recently I had had a bad headache at the end of my period twice. We were discussing the possibility of changes due to eventual menopause. (BCC 116848 – 116849)

19. The Enrollee stated she would have the Physician Assistant correct the errors in her medical record. She also offered to provide additional medical records from Dr. Katz and Dr. Woo, whom she saw during the past 20 years in Canada for her past reflux problems and other earlier conditions being investigated by Respondent.

20. On November 23, 2004 the Physician Assistant wrote to Respondent to correct the entries she made on the Enrollee's medical record. Excerpts from her letter are as follows:

> Her left kidney functions at 75% and her right kidney functions at 25% of normal. I mistakenly coded this as kidney disease when it should have read "kidney dysfunction"; this was my error. She has no active kidney disease. I am recoding the claim and resubmitting it to fix the error. At no time did I ever mean to convey that she had any type of rheumatoid arthritis . . . I don't know why this was interpreted by your company as "rheumatoid arthritis" when the word "arthritis" does not appear anywhere on the progress note, but in any case, it is incorrect. I did not actually diagnose her with "migraines" as you can see by the assessment portion of my progress note. (BCC 116876)

Additionally, the Physician Assistant found it necessary to provide guidance to Respondent's underwriting team on how to interpret her progress notes and stated:

> Just for future reference, the information written at the top of any progress note is called "Subjective" information by the patient. Nothing written in this portion should ever be taken to mean a previous diagnosis. It is all hearsay until proven through testing or examination. The "Assessment" portion of the note is the only information that should be considered true diagnoses.

21. On December 26, 2004 Respondent sent an updated request for information to the Enrollee. In the letter, Respondent acknowledged "[A] letter of clarification dated November 23, 2004 has been received from Regina Peterson, PA-C of Aragon Medical Center regarding office visit of August 26, 2004." However, that same letter fails to reflect any of the Physician Assistant's corrections noted in the letter of clarification. Instead, the letter reiterated the prior information despite the letter of clarification from the Physician Assistant which confirmed that she incorrectly coded the kidney disease that triggered the post-claims review and confirmed that Respondent had misinterpreted her progress note.

22. Respondent completely disregarded the letter of clarification from the Physician Assistant; none of the corrections provided by the Physician Assistant were reflected in Respondent's "update letter" of December 6, 2004. Respondent's "update letter" merely restated the same incorrect medical history and diagnosis codes set forth in Respondent's October 24, 2004 letter. It was the incorrect diagnosis codes and subjective information included in the progress notes that initially triggered Respondent's review of Enrollee's health history even though they were incorrect. Thus, had Respondent considered the information submitted by the Enrollee in her June 10, 2004 letter disclosing the tests and "reflux surgery," the information

provided in the Enrollee's appeal, or the letter of clarification from the Physician Assistant, it would have been apparent that rescission of the Enrollee's health care coverage was not justified.

23. Respondent rescinded the Enrollee's coverage on February 9, 2005. Respondent based its rescission of the Enrollee's health care coverage on the following health history and corresponding underwriting guidelines:

> Per our Medical Underwriting Guidelines, any applicant with a history of chronic pyelonephritis is not eligible for any of our medically underwritten plans.
>
> In addition, if it had been originally disclosed on your application that you had a history of Shigella food poisoning with recurrent back and hand stiffness, arthralgia, and fatigue for which additional testing was recommended, medical records would have been required to determine your eligibility. (BCC 006727 – 116730)

24. What Respondent failed to ascertain from its review of the Enrollee's medical records, her own explanation of her health history and the corrections submitted from the Physician Assistant is that both of the conditions noted above occurred well before the ten year time frame requested in the Health History section of Respondent's application. Specifically, the Enrollee was diagnosed with chronic pyelonephritis in 1983. The Enrollee's medical records and her own explanation of her condition confirm that the pyelonephritis was caused by a reflux condition that resolved following two ureter implantation surgeries at age 14 and 18, over twenty years before she applied for coverage with Respondent. The Enrollee continued to have a small right kidney, but there is no indication that she had any further complications following the ureter implantation surgeries as all subsequent testing came back as normal. Moreover, she was never diagnosed with kidney disease as stated in her medical records and in the letter of clarification from the Physician Assistant.

25. The Enrollee was diagnosed with Shigella in April, 1989 and suffered from reactive arthritis and arthralgia as a result. On July 4, 1994, she saw a rheumatoid specialist for these conditions. The physician's notes state:

> She was well until 5 years ago when she developed what was felt to be reactive arthritis. She was documented to have Shigella at the time . . . The entire episode lasted about two years and slowly resolved . . . Since

that time she has been well but she usually has a flare in January or February. . . She really has improved over the last month and had not required medication . . .This has not interfered with her activities or daily living. She likely does have reactive arthritis. (BCC 116739)

26. Respondent admitted that there was never a definitive diagnosis from this visit and medical records provided to Respondent confirm that Enrollee no longer complained about these conditions following the July 4, 1994 consultation. Moreover, Respondents Underwriting Guidelines do not include criteria for underwriting reactive arthritis, arthralgia or fatigue. Therefore, these conditions would not have required a rate up or decline of coverage and should not have been relied on to support Respondent's rescission of the Enrollee's coverage.[3]

V.

FIRST CAUSE FOR DISCLIPLINE

(Failing to Complete Medical Underwriting or Resolve All Reasonable Questions Arising From the Information Submitted on or with the Application Before Issuing Plan Coverage)

27. Complainant incorporates the provisions of paragraphs 1 through 26 above, and realleges them as though fully set forth herein.

28. Respondent is subject to an administrative penalty for failing to conduct a proper pre-enrollment underwriting review or investigation to resolve all reasonable questions arising from the information submitted on or with Respondent's Application for Individual Coverage before issuing health care coverage to the Enrollee for the following reasons:

(a) Because the proof of residency was required before the Enrollee's coverage was approved, Respondent had additional health information to evaluate and underwrite before issuing the plan contract based on the disclosures in the Enrollee's June 10, 2004 letter. Respondent admitted in hindsight, that there was confusion as to what condition required "reflux surgery," but failed to follow up on the additional disclosures made by the Enrollee failed to do so. As a result, Respondent failed to resolve all reasonable questions arising from the information submitted on or with the application for health care coverage in violation of section 1389.3.

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[3] Documentation provided by Respondent in this case only included underwriting guidelines for pyelonephritis indicating that Respondent relied on this condition to rescind coverage. A review of Respondent's underwriting guidelines produced to the Department pursuant to a subpoena duces tecum in Enforcement Matter 06-137 confirms that Respondent's underwriting guidelines do not include underwriting criteria for reactive arthritis, arthralgia or fatigue.

(b) The Enrollee's June 10, 2004 letter disclosed that she had "reflux surgery" but no time frame was indicated and Respondent made no attempt to follow up on when the "reflux surgery" was performed or what condition required surgery. Had Respondent contacted the Enrollee to discuss this additional health history before final approval of coverage, she could have explained that the "reflux surgery" occurred over 23 years before she applied for coverage with Respondent. Additionally, this would have provided the Enrollee with an opportunity to explain that her "reflux surgery" was necessary to correct her pyelonephritis, the very condition Respondent relied on to rescind her health care coverage. Thus, a call to the Enrollee would have allowed Respondent to resolve all reasonable questions submitted on or with the application before approving coverage.[4] Respondent failed to do so.

29. Respondent's failure to complete medical underwriting and properly investigate the additional health information disclosed by the Enrollee led to the wrongful rescission of coverage. Had Respondent investigated the additional disclosures made by the Enrollee, before issuing health care coverage, it would have understood that the pyelonephritis diagnosis was made and resolved over 20 years before the Enrollee applied for coverage following the "reflux surgery" disclosed by the Enrollee. Therefore, Respondent was not justified in rescinding the Enrollee's coverage based on its own admission that Health & Safety Code section 1389.3 "[p]rohibits rescission where "reasonable questions" arose in the underwriting process, but were not resolved."[5] On this basis alone, Respondent violated section 1389.3.

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[4] Although the effective date of the Enrollees' coverage was June 1, 2004, Respondent's final approval of the Enrollees' application came after it received the June 10, 2004 letter confirming residency and disclosing the additional tests and "reflux surgery." It was this information, submitted with the application for final approval that should have prompted Respondent to realize that it had not resolved all reasonable questions before issuing coverage.

[5] See Respondent's Response to the Department of Managed Health Care's Interrogatories, Set One, No. 55.

VI.

SECOND CAUSE FOR DISCIPLINE

(Failing to Make a Showing of Willful Misrepresentation Before Rescinding the Enrollee's Health Care Coverage)

30. Complainant incorporates the provisions of paragraphs 1 through 29 above, and realleges them as though fully set forth herein.

31. Respondent is subject to an administrative penalty for failing to meet its burden of showing that the Enrollee willfully misrepresented her health history before rescinding coverage.

32. The following facts evidence Respondent's failure to adequately investigate the Enrollee's health history and information submitted during the Enrollee's appeal of Respondent's rescission:

(a) Respondent's underwriting specialist solely based the decision to rescind coverage on the Enrollee's "history of chronic pyelonephritis" without questioning the significance of a diagnosis made over twenty years before she applied for coverage with Respondent. Had the underwriter contacted the Enrollee or conducted any investigation of the Enrollee's state of mind, or intent to deceive, he would have realized the pyelonephritis condition was resolved by surgery more than 20 years before the Enrollee applied for coverage.

(b) There is no evidence that Respondent considered Enrollee's explanation of her health history and it completely disregarded the letter of clarification provided by the Physician Assistant which explained that there were errors in the claim that triggered Respondent's review of her health history.

(c) Respondent engaged in an extensive review of medical records and rescinded Enrollee's coverage because she failed to disclose conditions that were diagnosed and treated more than 10 years before she applied for coverage with Respondent.

(d) Respondent relied on a medical record that indicated the Enrollee may have had reactive arthritis in July of 1994 and as noted in the rescission letter, "Followup records showing a definitive diagnosis was not received." Therefore, Respondent relied on speculative medical records showing no definitive diagnosis of reactive arthritis but still relied on this undiagnosed condition in an attempt to further justify its rescission of the Enrollee's health care coverage.

(e) Respondent's Medical Underwriting Guidelines do not evaluate reactive arthritis, arhthralgia or fatigue. Therefore, there is no indication that these conditions would have prompted Respondent to decline coverage to the Enrollee. Moreover, the Enrollee stated in her appeal letter that her reactive arthritis had resolved.

Therefore, Respondent should have contacted the Enrollee to confirm whether she was diagnosed or continued to suffer from reactive arthritis before rescinding her coverage.

(f) Respondent failed to conduct any investigation into whether the Enrollee omitted relevant information sought in the application or whether any such omission, if it existed, was willful.

33. Based on the foregoing, Respondent failed to establish that Enrollee willfully misrepresented her health history before it rescinded her coverage. Instead, Respondent's underwriting team disregarded information included in Enrollee's medical records, the information provided by the Enrollee in her June 10, 2004 letter and subsequent appeals and the letter of clarification from the Physician Assistant. Respondent failed to make a showing of willful misrepresentation before rescinding the Enrollee's health care coverage in violation of Health & Safety Code section 1389.3.

VII.

DISCIPLINARY CONSIDERATIONS

34. The Director of the Department has the discretion, pursuant to the provisions of the Health and Safety Code section 1386, subdivision (a), to assess administrative penalties as well as to suspend or revoke the license of a health care service plan for violations of the Act.

35. Complainant has considered the following factors in seeking an assessment of an administrative penalty of $200,000 against the Respondent in this action:

(a) This matter involves serious and egregious conduct. Respondent failed to complete medical underwriting and resolve all reasonable questions arising from the information submitted on or with the application before approving the Enrollee's coverage. It was this error that ultimately led to the wrongful rescission during Respondent's post-claims review of the Enrollee's health history.

(b) Respondent claims that the initial disclosures made by the Enrollee in her June 10, 2004 letter were not material to its underwriting but later, based its decision to rescind on a condition that was diagnosed and resolved over twenty (20) years before the Enrollee applied for coverage. Had Respondent resolved all questions before issuing coverage, and followed up on the Enrollee's disclosure of "reflux surgery," the harsh remedy of rescission could have been avoided.

(c) Respondent admitted that "in hindsight, the Enrollee's disclosure of "reflux

surgery" led to "confusion as to what the test disclosures referred to." A clear admission that Respondent did not resolve all reasonable questions arising from or submitted with the application for health care coverage in violation of section 1389.3 and its own policies and procedures for rescission.[6]

(d) Even though Respondent's own policies, and section 1389.3 prohibit Respondent from rescinding coverage in cases where it failed to resolve all reasonable questions before issuing coverage, it ignored all explanations provided by the Enrollee in the June 10, 2004 letter, her subsequent appeals and the letter of clarification from the Enrollee's Physician Assistant and wrongfully rescinded coverage.

(e) Respondent made no attempt to meet its burden of demonstrating that the Enrollee willfully misrepresented her health history before rescinding coverage in violation of section 1389.3 of the Act.

(f) Respondent's violation of the Act is not an isolated incident. During a non-routine survey conducted by the Department, several cases of wrongful or questionable rescissions were identified by the survey team. Moreover, it was discovered that Respondent had no current policies and procedures in place, other than its Underwriting Guidelines, to guide its underwriters when conducting post-claim reviews for rescission of coverage.

(g) Respondent is one of the largest health care service plans in the State of California, with 4,454,469 enrollees, total annual revenues of $2,953,621,000 and annual net income of $181,164,000 as of June 30, 2006.

(h) The financial penalty necessary to deter similar violations in the future is the sum of $200,000. Respondent can sustain this penalty amount because it is only .0000677 percent of the Respondent's annual revenues of over $2.9 billion as of June 30, 2006.

Dated: September 20, 2006

AMY L. DOBBERTEEN
Assistant Deputy Director
Department of Managed Health Care

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[6] See Respondent's Response to the Department of Managed Health Care's Interrogatories, Set One, No. 55.